NC DMA Request for Prior Approval CMN/PA

Continuation Form

Recipient Information **DMA-0011**

1. Recipient Last Name:_____ 2. First Name:_____

3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Provider Information

6. Requesting/Billing Provider #:_____NPI: ☐ Atypical: ☐ 7. Taxonomy: _____

8. Address: _____ 9. Nine Digit Zip Code: _____

Requestor Contact Information

Name:_____ Phone #:_____ Ext:_____ Fax: _____

Additional Medical Necessity Information

10. Medical Necessity of equipment: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Attach additional pages if necessary

Additional Service Information

	From Date	To Date	New/Used/Rental	HCPCS Code	Equipment Description
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					

This form must be submitted with a CMN/PA form. Do not submit this form alone.

Fax this form to CSC at: (855) 710-1964

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp